

State of California
Department of Industrial Relations
DIVISION OF WORKERS' COMPENSATION
455 Golden Gate Avenue, 9th Floor
San Francisco, CA 94102

FINAL STATEMENT OF REASONS

Subject Matter of Regulations: Workers' Compensation – Official Medical Fee Schedule

The Administrative Director of the Division of Workers' Compensation, pursuant to the authority vested in him by Labor Code Sections 59, 129, 129.5, 133, 5307.1, 5307.3, and 5318 has adopted Article 5.3 of Chapter 4.5, Subchapter 1, of Title 8, California Code of Regulations, commencing with Section 9789.10.

Section 9789.10	Physician Services – Definition
Section 9789.11	Physician Services Rendered on or after July 1, 2004
Section 9789.20	General Information for Inpatient Hospital Fee Schedule – Discharge on or after July 1, 2004
Section 9789.21	Definitions for Inpatient Hospital Fee Schedule
Section 9789.22	Payment of Inpatient Hospital Services
Section 9789.23	Hospital Cost to Charge Ratios, Hospital Specific Outlier Factors, and Hospital Composite Factors
Section 9789.24	Diagnostic Related Groups, Relative Weights, Geometric Mean Length of Stay
Section 9789.30	Hospital Outpatient Departments and Ambulatory Surgical Centers - Definitions
Section 9789.31	Hospital Outpatient Departments and Ambulatory Surgical Centers – Adoption of Standards
Section 9789.32	Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule – Applicability
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Section 9789.34	Table A
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Section 9789.70	Ambulance Services
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Section 9789.90	Home Health Care [Reserved]
Section 9789.100	Outpatient Renal Dialysis [Reserved]
Section 9789.110	Update of Rules to Reflect Changes in the Medicare Payment System

A. UPDATE OF INITIAL STATEMENT OF REASONS AND INFORMATIVE DIGEST

Pursuant to Government Code Section 11346.9(b), the Administrative Director of the Division of Workers' Compensation (hereinafter "Administrative Director") incorporates the Initial Statement of Reasons and Informative Digest prepared in this matter. There have been no changes to the statutes directly relating to this rulemaking. The proposed regulation changes are summarized below.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND CIRCULATED FOR A 15-DAY COMMENT PERIOD (MARCH 18, 2004 TO APRIL 2, 2004).

Modifications to Section 9789.10 Physician Services – Definition

Subdivision (d) is amended to include the codes listed in the "Physicians' Current Procedural Terminology (CPT) 1994," copyright 1993, American Medical Association, within the definition of "CPT®." Such codes are utilized in the Physical Medicine section of the OMFS 2003.

Modifications to Section 9789.11 Physician Services Rendered After January 1, 2004

The "General Information and Instructions, Effective for Dates of Service after January 1, 2004," which is incorporated by reference into Subdivision (a)(1), has been amended. Changes include:

- Page 1 – clarification that licensed hospitals, surgical facilities, and ambulatory surgical centers are entitled to facility fees for the use of the emergency room or operating room.
- Page 2 – express listing of procedures in the Special Services and Reports section of the OMFS 2003 that will not be valid for services rendered after January 1, 2004.
- Page 3 - clarification that any procedure code in the OMFS 2003 that is reimbursed at a rate greater than 100% of the Medicare rate (adopted for Calendar Year 2004) will be reduced up to 5% so that reimbursement will not fall below the Medicare rate.
- Page 4 - requiring that documentation of the actual cost of durable medical equipment may be requested by the payer. Such documentation may include, if applicable, a best or preferred price list.
- Page 4 - clarification that for any supply or material not covered by or listed in the Medicare DMEPOS fee schedule, the maximum reasonable fee paid shall not exceed that set forth in the OMFS 2003. Procedures and formulas for the payment of unlisted supplies or materials are included.
- Page 4 – inclusion of Pharmaceuticals section. Clarification that listed immunizations are reimbursable "By Report" plus a \$15.00 injection fee.
- Page 4 & 5 - clarification that for any pharmacy service or drug not covered by or listed in the relevant Medi-Cal payment system, the maximum reasonable fee paid shall not exceed that set forth in the OMFS 2003. Procedures and formulas for the payment of unlisted pharmacy services or drugs are included.

Subdivision (b) is amended to clarify that any procedure code in the OMFS 2003 that is reimbursed at a rate greater than 100% of the Medicare rate (adopted for Calendar Year 2004) will be reduced up to 5% so that reimbursement will not fall below the Medicare rate.

Subdivision (e) is amended to clarify that except for listed exceptions, pathology and laboratory services will be reimbursed under Section 9789.50.

Modifications to Section 9789.20 General Information for Inpatient Hospital Fee Schedule – Discharge after January 1, 2004

In response to comments, Section 9789.20(d) is amended to specify that the Inpatient Hospital Fee Schedule will be adjusted to conform to Medicare’s mid year updates within 60 days and that the annual updates will be effective every year on October 1. The word “will” is replaced with the word “shall.”

Modifications to Section 9789.21 Definitions for Inpatient Hospital Fee Schedule

Section 9789.21(d): This subdivision is amended to clarify that new technology payments are excluded when determining the composite factor.

Section 9789.21(d)(2)(B) and (D): The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173 (“MMA”) modified the calculation for large urban areas. Therefore, these subdivisions are corrected and the MMA reference is added.

Section 9789.21(d)(2)(E): The MMA modified the calculation for the disproportionate share adjustment factor. Therefore, the MMA reference is added.

Section 9789.21(d)(2)(F): The MMA modified the calculation for the indirect medical education adjustment. Therefore, the MMA reference is added.

Section 9789.21(e): This subdivision is amended to include implantable medical devices (which is referenced in 9789.22(f)).

Section 9789.21(g): This subdivision is edited to provide the correct definition of “cost outlier case.”

Section 9789.21(h): This subdivision is amended to include the payment for new medical services and new technology as part of the “cost outlier threshold.”

Section 9789.21(q)(1): The words “geographic adjustment factor” are replaced with “wage index.”

Modifications to Section 9789.22 Payment of Inpatient Hospital Services

Section 9789.22(b): This subdivision is added to specify that inpatient operating costs and capital-related costs are included in the inpatient hospital fee schedule maximum payment amount.

Section 9789.22(c): This subdivision is added to specify that the maximum payment does not include the cost items specified in Title 42, Code of Federal Regulations, §412(e)(1)(2)(3) and (5). It also provides that the maximum allowable fees for organ and tissue acquisition shall be based on the documented paid cost of procuring the organ or tissue.

After adding subdivisions (b) and (c), the remaining subdivisions have been re-numbered in sequential order, and cross references to the other subdivisions are corrected.

Section 9789.22(e)(3) and (4): The new technology pass-through payment is added to these sections which explain the formula for cost outlier cases.

Section 9789.22(e)(5): The word “once” is replaced by the word “if.”

Section 9789.22(g) and (h): Reference to the Code of Federal Regulations is updated to include the October 1, 2003 revision.

Section 9789.22(i)(1): This subdivision is amended to exclude only the health facilities listed as exempt under Section 9789.22(j).

Section 9789.22(i)(2)(A): This subdivision is amended to include long-term hospitals.

Section 9789.23(i)(2)(B): In response to comments, this section is clarified primarily by removing the word “subsequent.”

Section 9789.23(j)(3) and (5): Reference to the Code of Federal Regulations is updated to include the October 1, 2003 revision. Also, the subdivision incorrectly cited Section 412.25 instead of 412.23. This is corrected.

Section 9789.23(j)(6): The reference to the (g)(2) (the transfer policy) is deleted. Although the rehabilitation hospital is exempt, the post acute transfer policy applies to a hospital that discharges to them.

Section 9789.23(j)(8) is added to provide that out of state hospitals are exempt from the maximum reimbursement formula.

Section 9789.23(k) is added for hospitals that are not listed on the Medicare Cost Report.

**Modifications to Section 9789.23 Hospital Cost to Charge Ratios, Hospital Specific
Outlier Factors, and Hospital Composite Factors**

The previous section is deleted and a revised section is provided. The calculations have been corrected to reflect the modifications made by The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, §§401, 402 and 502.

Modifications to Section 9789.30 Hospital Outpatient Departments and Ambulatory Surgical Centers – Definitions

Section 9789.30(a): This subdivision has been modified to insert the \$ sign before number 52.151.

Section 9789.30(d): This subdivision has been modified to delete the word “which” and add the word “that.”

Section 9789.30(e) and (f): These subdivisions have been modified to reflect the changes in the federal regulations.

Modifications to Section 9789.31 Hospital Outpatient Departments and Ambulatory Surgical Centers – Adoption of Standards

Section 9789.31(a): This subdivision has been modified to identify the November 7, 2003 CMS regulation reference number as CMS-1471-FC. The Section has further been modified to reflect that the November 7, 2003 regulation (CMS-1471-FC) setting forth the CMS 2004 HOPPS was changed on December 31, 2003 by CMS-1471-CN, as published in the Federal Register on December 31, 2003, Volume 68, No. 250, pages 75442 through 75445, and on January 6, 2004 by CMS-1371-IFC, as published in the Federal Register on January 6, 2004, Volume 69, No. 3, pages 820 through 844. The subdivision has been also modified to set forth the CMS website where CMS’ regulations may be accessed.

Modifications to Section 9789.32 Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule – Applicability

Section 9789.32(a): This subdivision has been modified to clarify that payment for other services furnished in conjunction with a surgical procedure or emergency room visit shall be in accordance with subdivision (c) of this Section.

Section 9789.32(c): This subdivision has been modified to clarify that the maximum allowable fees for services, drugs and supplies furnished by hospitals and ambulatory surgical centers that do not meet the requirements in (a) for a facility fee payment and are not bundled in the APC payment rate for a surgical service or emergency room visit will be determined pursuant to subparts (1)-(7).

Section 9789.32(c)(1): This subdivision has been deleted.

Section 9789.32(c)(2) and (c)(3): This subdivisions have been renumbered (c)(1) and (c)(2) respectively.

Section 9789.32(c)(5): This subdivision has been renumbered (c)(4).

Section 9789.32(c)(5): This subdivision has been added to state that the maximum allowable fees for the technical component of the diagnostic services with a status code indicator “X” shall be determined according to Section 9789.10 and Section 9789.11.

Section 9789.32(g): This subdivision has been added to reflect that out of state hospital outpatient departments and ambulatory surgical centers are exempt from this fee schedule.

Section 9789.32(h): This subdivision has been added to state that hospital outpatient departments and ambulatory surgical centers billing for facility fees and other services under this section shall present with their bill the name and physical address of the facility, the facility's Medicare Provider or UPIN (or, in the absence of the Medicare number, the OSHPD Facility Number). The Section further provides that the bill shall include the dates of service, the diagnosis and procedure codes and charges for each service, and the applicable APC codes.

Modifications to Section 9789.33 Hospital Outpatient Departments and Ambulatory Surgical Facilities Fee Schedule – Determination of Maximum Reasonable Fee

Section 9789.33(a)(1): This subdivision has been amended to include status code indicator “X.”

Section 9789.33(a)(3): This subdivision has been amended to provide that the formula for payment for procedure codes for devices with status code indicator “H” is: Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

Section 9789(b)(1)(C): This subdivision has been amended to provide that the formula for payment for procedure codes for devices with status code indicator “H” under the alternative payment methodology in subdivision (b) is: Documented paid costs, net of discounts and rebates, plus 10% not to exceed \$250.00, plus any sales tax and/or shipping and handling charges actually paid.

Section 9789(b)(1)(E): This subdivision has been added to provide that the formula to determine the maximum allowable payment pursuant to the alternative payment methodology in subdivision (b) for procedures codes for surgical procedures with status code indicator “X” when no APC payment is made for a procedure with status code indicator “S”, “T”, or “V” is APC relative weight x adjusted conversion factor x 1.20.

Section 9789(b)(3): This subdivision has been amended to delete the word “standard.”

Section 9789.33(d): This subdivision has been renumbered subdivision 9789.33(e). The new subdivision 9789.33(d) now provides that any ambulatory surgical center that believes its cost-to-charge ratio in connection with its election to participate in the alternative payment methodology for high cost outlier cases under Section 9789.33(b) was erroneously determined because of error in tabulating data may request the Administrative Director for a re-determination of its cost-to-charge ratio. Proposed section 9789.33(d) further provides that the

redetermination of its cost-to-charge ratio request shall be in writing, shall state the alleged error, and shall be supported by written documentation. Within 30 days after receiving a complete written request, the Administrative Director shall make a redetermination of the cost-to-charge ratio or reaffirm the published cost-to-charge ratio.

Section 9789.33(e) and (f): This subdivisions have been renumbered subdivisions 9789.33(f) and (g) respectively. Subdivision 9789.33(f), now subdivision 9789.33(g), has been modified to clarify that the payment determined under subdivisions (a) and (b) include reimbursement for all of the included cost items specified in 42 CFR § 419.2(b)(1)-(12). This subdivision has been further modified to move the last sentence to subdivision 9789.33(h).

Section 9789.33(h): This subdivision has been added to Section 9789.33. Subdivision 9789.33(h) contains the last sentence set forth at section 9789.33(f), now Section 9789.33(g), which has been modified to provide that the maximum allowable fee shall be determined without regard to the cost items specified in 42 C.F.R. § 419.2(c)(1), (2), (3), (4), and (6), as contained in Section 9789.38 Appendix X. This subdivision further provides that cost item set forth at 42 C.F.R. §419(c)(5), as contained in Section 9789.38 Appendix X, is payable pursuant to Section 9789.32(c)(2), and cost items set forth at 42 C.F.R. §419(c)(7) and (8), as contained in Section 9789.38 Appendix X, are payable pursuant to Section 9789.32(c)(3).

Section 9789.33(g): This subdivision has been renumbered Section 9789.33(i).

Modifications to Section 9789.34 Table A

Section 9789.34: This section has been modified for clarification to delete the parenthetical phrase contained in the last column of the Table A stating “(before CA WC Adjustment Factor).”

Modifications to Section 9789.35 Table B

Section 9789.35: This section has been modified for clarification to delete the parenthetical phrase contained in the last column of the Table B stating “(before CA WC Adjustment Factor).”

Modifications to Section 9789.36 Update of Rules to Reflect Changes in the Medicare Payment System.

Section 9789.36: This section has been modified to state that Sections 9789.30 through 9789.38 shall be adjusted to conform to any relevant changes in the Medicare payment schedule, including mid-year changes, no later than 60 days after the effective date of those changes. The Section has been further modified to state that updates shall be posted on the Division of Workers’ Compensation webpage at http://www.dir.ca.gov/DWC/dwc_home_page.htm, and that the annual updates to the Hospital Outpatient Departments and Ambulatory Surgical Centers Fee Schedule shall be effective every year on January 1.

Modifications to Section 9789.38 Appendix X

Section 9789.38 Appendix X: Proposed section 9789.38 sets forth the federal regulations which are incorporated by reference and/or referred to in Sections 9789.30 through 9789.36. The portions of the federal regulations set forth below were amended pursuant to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173).

42 C.F.R. § 419.32(d) is modified as follows: (d) Budget neutrality. (1) CMS adjusts the conversion factor as needed to ensure that updates and adjustments under § 419.50(a) are budget neutral. (2) In determining adjustments for 2004 and 2005, CMS will not take into account any additional expenditures per section 1833(t)(14) of the Act that would not have been made but for enactment of section 621 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

42 C.F.R. §419.43(d) is amended to modify the introductory text as follows: (d) outlier adjustment -- (1) General rule. Subject to paragraph (d)(4) of this section, CMS provides for an additional payment for a hospital outpatient service (or group of services) not excluded under paragraph (f) of this section for which a hospital's charges, adjusted to cost, exceed the following: ***

42 C.F.R. §419.43(e) is revised as follows: (e) Budget neutrality. CMS establishes payment under paragraph (d) of this section in a budget-neutral manner excluding services and groups specified in paragraph (f) of this section.

42 C.F.R. §419.43(f) is added to state: (f) Excluded services and groups. Drugs and biologicals that are paid under a separate APC and devices of brachytherapy, consisting of a seed or seeds (including radioactive source) are excluded from qualification for outlier payments.

42 C.F.R. § 419.64: 42 C.F.R. §419.64(d) is amended by revising paragraph (d) as follows: (d) Amount of pass-through payment. (1) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(A) and (o)(1)(D)(i) of the Act is 95 percent of the average wholesale price of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological. (2) Subject to any reduction determined under § 419.62(b), the pass-through payment for a drug or biological as specified in section 1842(o)(1)(B) and (o)(1)(E)(i) of the act is 85 percent of the average wholesale price, determined as of April 1, 2003, of the drug or biological minus the portion of the APC payment CMS determines is associated with the drug or biological.

42 C.F.R. §419.70 has been deleted as not applicable.

Modifications to Section 9789.40 Pharmacy

Subdivision (b) is added to provide that for a pharmacy service or drug that is not covered by a Medi-Cal payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003. This provision restates the mandate of Labor Code § 5307.1(e).

Modifications to Section 9789.50 Pathology and Laboratory

Subdivision (c) is added to provide that for any pathology and laboratory service not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003. This provision restates the mandate of Labor Code § 5307.1(e).

Modifications to Section 9789.60 Durable Medical Equipment, Prosthetics, Orthotics, Supplies

Subdivision (b) is amended to delete CPT Code 99070 as this code may be utilized to bill for an unlisted service.

Subdivision (c) is added to provide that for durable medical equipment, supplies and materials, orthotics, prosthetics, and miscellaneous supplies and services not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003. This provision restates the mandate of Labor Code § 5307.1(e).

Modifications to Section 9789.70 Ambulance Services

Subdivision (b) is added to provide that for any ambulance service not covered by a Medicare payment system, the maximum reasonable fee paid shall not exceed the fee specified in the OMFS 2003. This provision restates the mandate of Labor Code § 5307.1(e).

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE PUBLIC HEARING AND CIRCULATED FOR A 15-DAY COMMENT PERIOD (MARCH 30, 2004 TO APRIL 14, 2004).

Modifications to Section 9789.10. Physician Services - Definitions.

Subdivision (d) is modified to add a reference to Physicians' Current Procedural Terminology (CPT) 1994, as it is used in the coding structure of the OMFS 2003 as well as the 1997 CPT.

Subdivision (e) is modified to define "Medicare rate" as the physician fee schedule rate derived from the Resource Based Relative Value Scale and related data, adopted for the Calendar Year 2004, and published in the Federal Register on January 7, 2004, Volume 69, No. 4, pages 1117 through 1242 (CMS-1372-IFC), as amended by CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 105 (February 20, 2004). The Medicare rate for each procedure is derived by the Administrative Director utilizing the non-facility rate (or facility rate if no non-facility rate exists), and a weighted average geographic adjustment factor of 1.063.

Modifications to Section 9789.11(c) Physician Services – Definition

Subdivision (b) is modified to clarify that procedures reimbursed under OMFS 2003 rate below the Medicare rate will not be reduced.

Subdivision (c) incorporates by reference "Table A - OMFS Physician Services Fees for Services Rendered after January 1, 2004." The table proposed in the 45 day comment period is replaced by a new proposed Table A. This new table, which sets forth individual procedure

codes from the OMFS 2003 with each code's corresponding relative value, conversion factor, percentage reduction calculation (between 0 and 5.0%) mandated by Section 9789.11(b), and maximum reimbursable fee, is updated to reflect Medicare's adjusted 2004 Relative Value Units for the National Physician Fee Schedule, as mandated by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub. L. 108-173. The new Table A also: includes codes that were inadvertently omitted from the Table A proposed on January 12, 2004, corrects clerical errors, includes missing codes descriptions, and revises reductions proposed for codes listed under the Physical Medicine section of the 2003 OMFS. Many of the physical medicine codes that were previously reduced have been excluded from the reduction. This was done because reevaluation indicated that reimbursement for those codes under OMFS 2003 was below the Medicare rate.

Subdivision (e) adds language to clarify the applicability the fee schedule for pathology and laboratory services.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE COMMENT PERIOD ENDING APRIL 2, 2004 AND CIRCULATED FOR A 15-DAY COMMENT PERIOD (APRIL 9, 2004 TO APRIL 24, 2004).

Modifications to Section 9789.21 Definitions for Inpatient Hospital Fee Schedule

Section 9789.21(e) has been modified in response to a comment to specifically exclude "Durable Medical Equipment dispensed for home use" from "costs."

Modifications to Section 9789.22 Payment of Inpatient Hospital Services

Section 9789.22(c) has been modified as follows: the words "take into account" have been replaced with "include" to clarify that the listed items will not be reimbursed, unless otherwise stated.

Modifications to Section 9789.32 Outpatient Hospital Department and Ambulatory Surgical Center Fee Schedule – Applicability

Section 9789.32(a)(2): This subdivision stating that a supply, drug, device, blood product and biological is considered an integral part of an emergency room visit or surgical procedure if the item is assigned to the same APC as the emergency room visit or surgical procedure and has a status code indicator "H" has been deleted in response to comment requesting consistency in the regulation. Section 9789(a)(3), now renumbered Section 9789(a)(2), consistently identifies payment of status codes "G", "H", and "K".

Section 9789.32(c)(1): This subdivision has been amended in response to comment to clarify that the maximum allowable fees for the professional medical services which are performed by physicians and other licensed health care providers shall be paid according to Section 9789.10 and Section 9789.11.

Section 9789.32(c)(3): This subdivision was originally amended in response to comment to clarify that the maximum allowable fee for drugs shall be 100% of the fee prescribed by Medi-Cal pursuant to Labor Code Section 5307.1 subdivision (a), or, where applicable, Section 9789.40.

The subdivision was later modified to revert to the proposed language “not otherwise covered by a Medicare fee schedule payment for facility services” in Section 9789.32(c)(3) to avoid confusion in the regulation.

Section 9789.32(c)(5): This subdivision has been amended in response to comment to clarify that the maximum allowable fees for non-surgical ancillary services with a status code indicator “X” shall be determined according to Section 9789.10 and 9789.11.

Section 9789.32(h): This subdivision has been amended in response to comment to clarify the last sentence to provide that the bill shall include the dates of service, the diagnosis and current HCPCS codes and charges for each billed service, including HCPCS codes for any items and services that are packaged into the APC payment for a significant procedure.

Modifications to Section 9789.33 Hospital Outpatient Departments and Ambulatory Surgical Facilities Fee Schedule – Determination of Maximum Reasonable Fee

Section 9789.33(a)(1): This subdivision has been amended in response to comment to clarify that the payment formula indicated is applicable to CPT codes 99281-99285 and CPT codes 10040-69990 with status code indicators “S”, “T”, “X” or “V”.

Section 9789.33(b)(1)(A): This subdivision has been amended in response to comment to clarify that the payment formula indicated is applicable to CPT codes 99281-99285 and CPT codes 10040-69990 with status code indicators “S”, “T”, “X” or “V”.

Section 9789.33(b)(1)(E): This subdivision has been deleted in response to comment of inconsistency and as duplicative.

Section 9789.33(c)(1): This subdivision has been amended for clarification purposes to indicate that DWC Form 15 “Election for High Cost Outlier,” contained in Section 9789.37 must be filed with the Division of Workers’ Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 8888, San Francisco, CA 94128, and that the form must be post-marked by March 1 of each year.

Section 9789.33(c)(5): This subdivision has been amended for clarification purposes to indicate that a copy of the Annual Utilization Report of Specialty Clinics may also be obtained upon request to the Division of Workers’ Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 8888, San Francisco, CA 94128.

Section 9789.33(c)(6): This subdivision has been amended for clarification purposes to indicate that the list of facilities that have elected to be paid under Section 9789.33(b) is available upon

request to the Division of Workers' Compensation, Medical Unit (Attention: OMFS-Outpatient), P.O. Box 8888, San Francisco, CA 94128.

THE FOLLOWING SECTIONS WERE AMENDED FOLLOWING THE COMMENT PERIOD ENDING APRIL 2, 2004 AND CIRCULATED FOR A 15-DAY COMMENT PERIOD (APRIL 13, 2004 TO APRIL 28, 2004).

Modifications to Section 9789.10 subdivision (c) Physician Services – Table A – Corrections Necessitated by Inadvertent Use of 1.06 GPCI Instead of 1.063 GPCI In Calculating the Medicare Rate Used for Comparison

Section 9789.10 subdivision (c), Table A has been modified to correct some errors in the Table A that was sent for a 15-Day comment period on March 30th, ending on April 14, 2004. It has been determined that the calculations used to determine the maximum allowable fee set forth in the modified proposal whose comment period ends April 14th contained errors in some codes. These errors were the result of applying a 1.06 Geographic Practice Expense Index (GPCI) instead of a 1.063 GPCI to determine the Medicare rate used in the comparison to the OMFS 2003 fee. As a result of dropping the third decimal place, there were a few codes whose values were affected. This modified proposal for 15-day comment period sets forth the changes to the maximum reimbursable fees by re-calculating using the 1.063, and sets forth the percent reduction calculation. The percent reduction calculation and new maximum allowable fee will be integrated into the final Table A, but are set forth separately here for the convenience to the public. The other items for each of these codes, relative value, conversion factor, descriptor, remain the same as in the Table A proposed for public comment on March 30th (with comment ending on April 14, 2004) and will be integrated into the Table A at the time of final adoption so that the public will have one consolidated table of these physician fees.

Modifications to Section 9789.10 subdivision (c) Physician Services – Table A – Corrections to Acupuncture Codes

This proposal modifies two table entries relating to acupuncture, codes 97802 (cupping) and 97803 (moxibustion in acupuncture). These codes were listed as having only a .4% reduction in fee from the OMFS 2003. These codes should actually have a 5% reduction. In accordance with the statute, the OMFS 2003 codes are reduced by 5%, but the Administrative Director was given discretion to reduce by a different amount so that a code would not go below the Medicare rate. These two codes were erroneously compared to the Medicare codes 97802 and 97803, but in Medicare those code numbers relate to medical nutritional therapy, not acupuncture. There are no Medicare codes or reimbursements for cupping or moxibustion; therefore the 5% reduction to the OMFS 2003 should be applied to establish the new fee. The .4 % reduction was the result of erroneously comparing the 97802 and 97803 OMFS cupping and acupuncture codes to the nutritional therapy codes.

Modifications to Various Sections to Clarify the Effective Date of the Changes Made Through this Rulemaking Action – Physician Services Sections 9789.10-9789.11, Inpatient Services Sections 9789.20-9789.24, Outpatient Services Sections 9789.30 - 9789.38

Changes are proposed to various parts of the Official Medical Fee Schedule regulations to clarify the effective date of the regulations. Specifically, the regulatory text relating to Physician Services and Outpatient Services are amended to clearly indicate that they will apply prospectively to services rendered on or after July 1, 2004. In relation to Inpatient Hospital Services the regulatory text is modified to make it clear that the new regulations will apply to services where the date of discharge is on or after on or after July 1, 2004. All three of these components of the schedule involve substantive changes, including changes of fee levels that should be given prospective application only.

The other components of the fee schedule, Pharmacy, Section 9789.40, Pathology and Laboratory, Section 9789.50, Durable Medical Equipment, Prosthetics, Orthotics, Supplies, Section 9789.60, and Ambulance Services, Section 9789.70 have not had any substantive changes made during this rulemaking. The effective date for those sections remains as “services rendered after January 1, 2004”. The changes made in this rulemaking merely add clarifying language, which mirrors the provision of the statute, that services not covered by those Medicare schedules, or the Medi-Cal schedule for pharmacy, are paid at no more than the rate set forth in the OMFS in effect on December 31, 2003.

Addition of New Section 9789.111 to Clarify Effective Date of Official Medical Fee Schedule

This proposal adds a new Section 9789.111. This is done to provide clarity regarding the effective date of the various portions of the fee schedule. The emergency regulations adopted for physician services, inpatient services, and outpatient services, which are effective for services after January 1, 2004 are intended to remain in effect and apply to services rendered up to June 30, 2004. The new regulations will apply to services rendered on or after July 1, 2004. It is necessary to clarify this as these regulations which change substantive provisions, including calculation of medical fees, should be prospective only. The new Section 9789.111 clarifies that as to the pharmacy, pathology and laboratory, Durable Medical Equipment, Prosthetics, Orthotics, Supplies, and Ambulance services, the rules apply for services rendered after January 1, 2004. These schedules do not need to have a new effective date as the only changes to them insert language to draw attention to the statutory provision that items not covered by those schedules are to be paid under the OMFS in effect on December 31, 2004. As such, they are merely clarifying and can continue to operate for services rendered after January 1, 2004.

THE FOLLOWING NON-SUBSTANTIVE / CORRECTIONS WITHOUT REGULATORY EFFECT WERE MADE TO THE TEXT OF THE REGULATIONS AFTER THE CLOSE OF THE FINAL COMMENT PERIOD

Section 9789.10 (a)(1) General Instructions

The text of the General Instructions relating to the Special Reports has been changed to conform to the statutory directive in Labor Code Section 5307.1 (k) that physician service rates shall be reduced by 5 percent in calendar years 2004 and 2005. This also conforms the narrative text in the General Instructions to the regulatory text set forth in Section 9789.11(b), and to the value

for Code 99081 set forth in Table A (Section 9789.11(c)) as distributed in the public comment periods.

Section 9789.11 (c) Table A

For clarity the order of the codes was changed to conform to the OMFS 2003 book. In addition, the display of codes was changed on codes having professional/technical component split to show the RVUs on the global payment line only instead of repeating the data on each line. This does not have regulatory effect, but improves the clarity of the display of data in the Table.

Section 9789.110 Update of Rules to Reflect Changes in the Medicare Payment System

This section states that the Division will update the fee schedule to conform to changes in Medicare and Medi-Cal systems and that such changes will be posted on the Division's website. The text has been changed to delete a repetitive reference to "Medicare". The section was also changed to state that the OMFS shall be adjusted "within 60 days". This was done for clarity in response to a comment suggesting the addition, as 60 days is the statutory time period for the updates. The inclusion of this phrase does not in itself have a regulatory effect as it is the statute that mandates the 60 day time frame.

UPDATE OF MATERIAL RELIED UPON / DOCUMENTS ADDED TO RULEMAKING FILE

In addition to the documents identified in the Initial Statement of Reasons the following documents were relied upon by the Division and were made available to the public as required by Government Code Section 11347.1.

Title of Document Added to Rulemaking File	Dates of Availability for Public Comment
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CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 through 75445.	March 18, 2004 – April 2, 2004
CMS-1371-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820 through 844.	
Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173.	
Title 42, Code of Federal Regulations, Sections 412.2, 412.23, 412.87, 412.88, and 412.92, revised as of October 1, 2003.	
Title 42, Code of Federal Regulations, Sections 419.32, 419.43, 419.64, revised as of January 6, 2004.	

CMS-1372-IFC, Federal Register, Volume 69, No. 4 (January 7, 2004), pages 1117 through 1242. CMS Manual System, Pub. 100-04 Medicare Claims Processing, Transmittal 105 (February 20, 2004).	March 30 – April 14, 2004
<i>Suggested Alternatives for the Inpatient Hospital Fee Schedule</i> , prepared by the Division of Workers’ Compensation, Commission on Health and Safety and Workers’ Compensation with cover letter dated June 19, 2002, and July 9, 2002 attendance sheet. <i>Report to the Congress, Medicare Payment Policy</i> , prepared by the Medicare Payment Advisory Commission, dated March 2003.	April 9 – April 24, 2004
Excel spreadsheet entitled “OMFS – Recalculated Codes – 1.063 Statewide GPCI”.	April 13 – April 28, 2004

JUSTIFICATION FOR DOCUMENTS INCORPORATED BY REFERENCE

Section 9789.11

- “General Information and Instructions, Effective for Dates of Service on or after July 1, 2004”
- Table A, “OMFS Physician Services Fees for Services Rendered on or After July 1, 2004”

These two documents are part of this rulemaking. They are part of the revised OMFS for physician services. The entire physician section of the OMFS is a book consisting of hundreds of pages, which can be obtained from the Division of Workers’ Compensation.

Section 9789.21

- Federal Register, Volume 68, No. 193 (October 6, 2003), pages 57735, Table 1 A; pages 57735 - 57736, Table 1D; page 57736 - 57743, Table 4A; pages 57743 - 57744, Table 4B, page 57744 - 57745, Table 4C.
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173.

- 2004 Prospective Payment System Payment Impact File (October 2003 Update) (IMPF04) published by the federal Centers for Medicare & Medicaid Services.

The calculations needed by the public in order to determine the maximum payment for inpatient medical services are set forth in Section 9789.23. The above referenced documents contain the information used in the calculations. The public may refer to Section 9789.23 instead of the incorporated documents in order to comply with the regulations. Therefore, the entire documents are not contained within the regulations. Additionally, the cited sections of the Federal Register consist of 10 pages, and the Medicare Prescription Drug, Improvement and Modernization Act of 2003 is 442 pages. The Payment Impact file is an extensive interactive Excel File. The internet address to access the file is provided.

Section 9789.22

- Title 42, Code of Federal Regulations, Sections 412.2, 412.23, 412.87, 412.88, and 412.92, revised as of October 1, 2003.

Sections 412.1 et seq. are the Medicare Inpatient Prospective Payment System. The entire section is voluminous and the reproduction of out-of-context excerpts is not useful. These sections are easily obtainable on line or in print.

Section 9789.31

- Centers for Medicare and Medicaid Services' (CMS) 2004 Hospital Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, published in the Federal Register, Volume 68, No. 216, Addendum A through J, pages 63478 – 63690 (CMS-1471-FC), as changes by CMS-1471-CN, Federal Register, Volume 68, No. 250 (December 31, 2003), pages 75442 – 75445, and CMS-1317-IFC, Federal Register, Volume 69, No. 3 (January 6, 2004), pages 820-844.193 (November 7, 2003), pages 57735, Table 1 A; pages 57735.

These documents represent the Centers for Medicare and Medicaid Services (CMS) Hospital Outpatient Prospective Payment System (HOPPS), adopted for the Calendar Year 2004, and amended on 12/31/03 and on 1/6/04. These documents are voluminous and can be easily obtained from CMS' website as provided in the regulations. Table A in Section 9789.34 and Table B in Section 9789.5 have been developed to aid the regulated public in obtaining the Adjusted Conversion Factor for the California OMFS.

- American Medical Associations' Physician's Current Procedural Terminology (CPT), 2004 Edition.

This is a copyrighted document. Additionally, it is a book which is hundreds of pages long.

- CMS' 2004 Alphanumeric Healthcare Common Procedure Coding System (HCPCS)

This is a copyrighted document. Additionally, it is a book which is hundreds of pages long.

Section 9789.33

- 42 C.F.R. §§419.2, 419.32, 419.43, 419.44, 419.62, 419.64, 419.66

These sections are reproduced and contained in Section 9789.38 as Appendix X.

- Annual Utilization Report of Specialty Clinics filed with Office of Statewide Health Planning and Development (OSHDP)

Ambulatory Surgical Centers are required under the law to file this report with OSHPD. The report is submitted on a yearly basis. The regulations required a copy of the completed and filed report. The website address for this document is provided in Section 9789.37. It may also be obtained from the Division of Workers' Compensation.

Section 9789.50

- CMS' Clinical Diagnostic Laboratory Fee Schedule, as established by Sections 1833 and 1834 of the Social Security Act (42 U.S.C. §§ 1395l and 1395m)

This is an extensive document that can be easily obtained on line, in print, or from the Division of Worker's Compensation.

Section 9789.60

- CMS' Durable Medical Equipment, Prosthetics/Orthotics, and Supplies (DMEPOS) Fee Schedule, as established by Section 1834 of the Social Security Act (42 U.S.C. § 1395m)

This is an extensive document that can be easily obtained on line, in print, or from the Division of Worker's Compensation.

Section 9789.70

- CMS's Ambulance Fee Schedule, which is established pursuant to Section 1834 of the Social Security Act (42 U.S.C. § 1395m)

This is an extensive document that can be easily obtained on line, in print, or from the Division of Worker's Compensation.

LOCAL MANDATES DETERMINATION

- Local Mandate: None. The proposed regulations will not impose any new mandated programs or increased service levels on any local agency or school district. The proposed amendments to not apply to any local agency or school district.
- Cost to any local agency or school district that is required to be reimbursed under Part 7 (commencing with Section 17500) of Division 4 of the Government Code: None. The proposed amendments do not apply to any local agency or school district.
- Other nondiscretionary costs/savings imposed upon local agencies: None. The proposed amendments to not apply to any local agency or school district.

CONSIDERATION OF ALTERNATIVES

The Division considered all comments submitted during the public comment periods, and made modifications based on those comments to the regulations as initially proposed. The Administrative Director has now determined that no alternatives proposed by the regulated public or otherwise considered by the Division of Workers' Compensation would be more effective in carrying out the purpose for which these regulations were proposed, nor would they be as effective and less burdensome to affected private persons and businesses than the regulations that were adopted.

SUMMARY OF COMMENTS RECEIVED AND RESPONSES THERETO CONCERNING THE REGULATIONS ADOPTED

The comments of each organization or individual are addressed in the following charts.

The public comment periods were as follows:

Initial 45-day comment period on proposed regulations:

January 23, 2004 through March 11, 2004.

First 15-day comment period on modifications to proposed text:

March 18, 2004 through April 2, 2004.

Second 15-day comment period (concerning Section 9789.10 and 9789.11 only):

March 30, 2004 through April 14, 2004.

Third 15-day comment period (concerning Sections 9789.21, 9789.22, 9789.32 and 9789.33 only):

April 9, 2004 through April 24, 2004.

Fourth 15-day comment period on modifications to proposed text:

April 13, 2004 through April 28, 2004.